

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13041

13029

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED NAME (Type or print)	First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR Hour Min.
JENNIE AMANDA Anderson				SEPT. 15 1968	07 P.M.
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
FEMALE	WHITE	2-11-94	74 YRS.		
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH KENT CO.		
MARYLAND UNITED STATES					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	
CHESTER TOWN	KENT CO Queen Anne's			House WORK	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER	
MARYLAND	QUEEN ANNE'S	Sudlersville	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME	First Middle Last
John	Thomas	Anderson		Georgia	Burgess
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address		
NO	216-54-8985	Hospital Records	CHESTER TOWN, MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarct</u>					
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerosis</u>					
DUE TO, OR AS A CONSEQUENCE OF (c)					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hours					
years.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Obstruction of coronary artery causing intestinal obstruction</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town County State
22a. I certify that (I) (this hospital) attended the deceased from <u>8-7</u> , 19 <u>68</u> , to <u>Sept 15</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>9-15</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>A.C. Dick MD</u>					
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS <u>Chester Town, Md.</u>		22c. DATE SIGNED <u>9-15-68</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>9/18/68</u>		23c. NAME OF CEMETERY OR CREMATORIAL <u>Sudlersville Cemetery</u>	
24. FUNERAL DIRECTOR <u>Edward Fellows & Son,</u>		ADDRESS <u>Millington, Md. 21651</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 20 1968</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13030

13042

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. In any event, within 72 hours, the certificate should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours, with the State Dept. of Health.

1. DECEASED-NAME (Type or print)	First Rosie	Middle Mae	Last Blake	2a. DATE OF DEATH Month September	2b. HOUR Year 1968		
3. SEX Female	4. RACE Negro	5. DATE OF BIRTH May 6, 1934		6. AGE (In years last birthday) 34	7. IF UNDER 1 YEAR MONTHS YRS.	8. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? US	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Kent Co.			
10. CITY OR TOWN OF DEATH Chestertown	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Kent & Queen Anne's Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Kent	13c. CITY OR TOWN Chestertown	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER Rt. #2			
14. FATHER'S NAME First Edward	Middle Thomas	15. MOTHER'S MAIDEN NAME First M A R Y		Middle	Last Unk.		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. YES	17. INFORMANT Hospital Records, M	Address Chestertown, Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 174 X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 170 X						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
b) CARCINOMATOSIS DUE TO, OR AS A CONSEQUENCE OF CARCINOMA OF BREAST						4 Yes	
c) 170 X							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION 170 X		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from Sept. 25, 1968 , to Sept. 27, 1968 , that (I) (we) last saw the deceased alive on Sept. 27, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE O. S. Gulbrandsen, M.D.		22c. DATE SIGNED 9-27-68	DEGREE <input type="checkbox"/> MED. ATTENDING PHYS. <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				
22d. PHYSICIAN'S NAME (Type) O. S. Gulbrandsen, M.D.		22e. ADDRESS Chestertown, Maryland 21620					
23a. BURIAL, CREMATION, (Specify) Burial		23b. DATE 9/30/68	23c. NAME OF CEMETERY OR CREMATORIAL Sandy Bottom Cem.	23d. LOCATION (City or Town) R.F.D. Chestertown	(County) Kent	(State) Md.	
24. FUNERAL DIRECTOR Bennett Weller		ADDRESS Chestertown, Md.	25a. REC'D BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE Charles Judge	DATE OCT 3 1968		

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FOR STATE
HEALTH DEPT.

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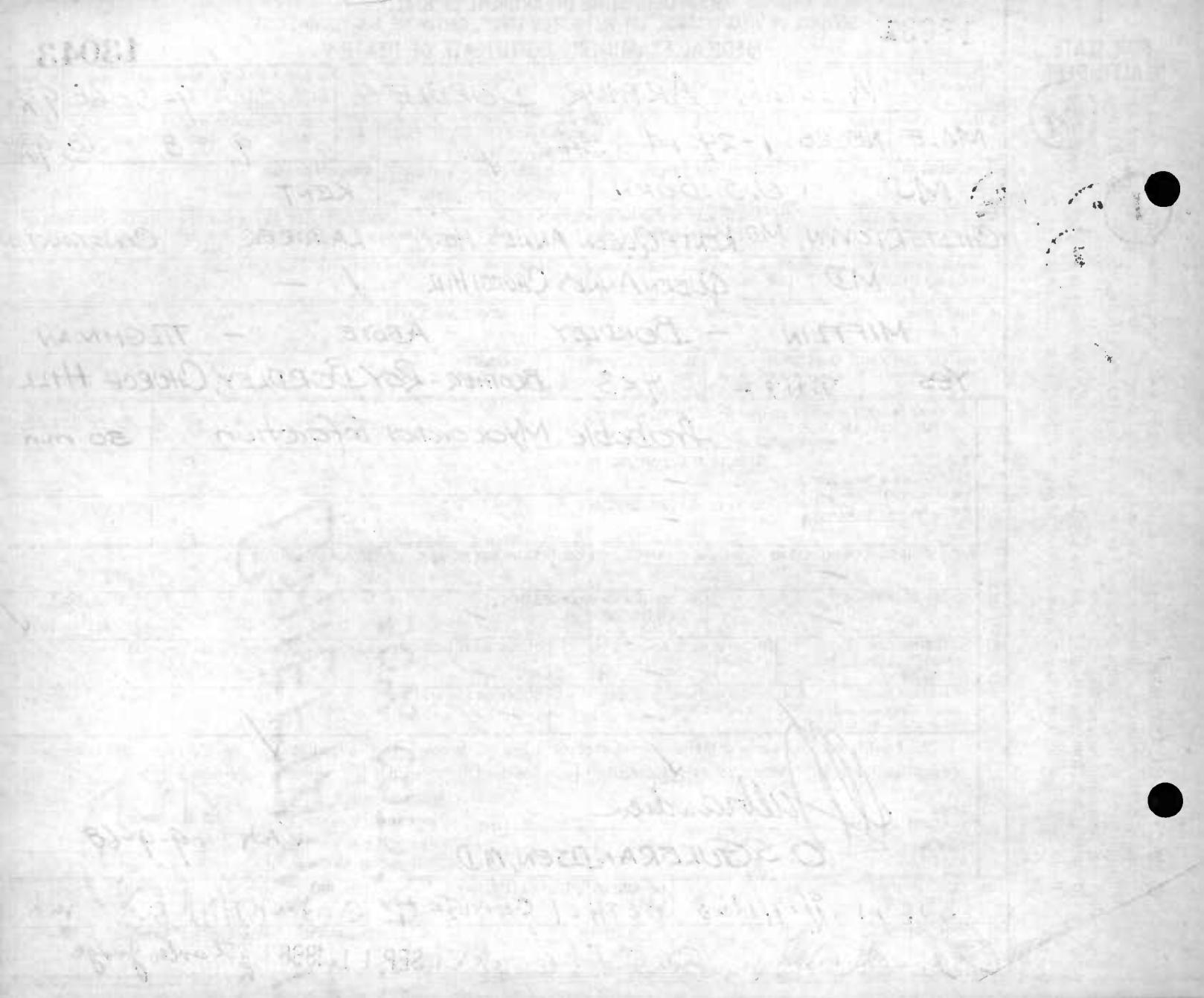
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13043

1. DECEASED-NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN BY ESTI- MATED	Month	Day	Year	2b. HOUR 9:25 A.M.
<i>WILLIAM ARTHUR BORDLEY</i>						<input checked="" type="checkbox"/>	9-8-68			
3. SEX	4. RACE	S. DATE OF BIRTH	6. AGE (in years less than 100) 34 yrs	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS					2d. HOUR 9:30 A.M.
MALE	NEGRO	1-29-14								
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8.	MARRIED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH			
MD.	U.S. BORN						KENT			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital check street address)			12a. USUAL OCCUPATION (Kind of work done during most recent 12 months if men if retired)			12b. KIND OF BUSINESS OR INDUSTRY			
CHESTERTOWN, MD	KENT & QUEEN ANNE'S Hosp			LABORER			CONSTRUCTION			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER							
MD	QUEEN ANNE'S CHURCH HALL	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	—							
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle	Lost			
I. MIFFLIN			BORDLEY	ABIE			—	—		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown)	16b. SOCIAL SECURITY NO. (If yes give war or dates of service)	16c. INFORMANT YES	ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
YES	WW 2	YES	BROTHER - ROY BORDLEY, CHURCH HILL			30 min				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Probable Myocardial Infarction</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) — DUE TO, OR AS A CONSEQUENCE OF (c) —										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1301 —										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. — 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) —				
21d. INJURY OCCURRED	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.			City or Town	County	State		
—	—		—			—	—	—		
22a. I certify that I am in charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Actual Signature <i>O. S. Gulbrandsen</i> EXAMINER'S NAME (Type) <i>O. S. GULBRANDSEN, M.D.</i> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Actg 22b. DATE SIGNED <i>9-9-68</i>										
23a. BURIAL, CREMATION, REMOVAL (Specify) Bur. & Crem.			23b. DATE 9/14/1968	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS			23d. LOCATION (City or Town) CHURCH HILL		(County) <i>Q.A.</i>	(State) <i>MD</i>
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		
<i>Dennett W. Miller</i>			Chesapeake, MD			SEP 11 1968				

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with four (4) P.M. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



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10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13032

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13044

1. DECEASED-NAME (Type or print)	First Alverta	Middle Lee	Last Bostic	2a. DATE OF DEATH Month 9	Day 9	Year 1968	2b. HOUR 2:20 M
3. SEX Female	4. RACE White	5. DATE OF BIRTH 10-3-04			6. AGE (In years last birthday) 63	IF UNDER 1 YEAR MONTHS YRS.	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? US	8. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Kent			
10. CITY OR TOWN OF DEATH Chestertown	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Kent & Queen Anne's Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working-life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Queen Anne	13c. CITY OR TOWN Sudlersville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER none			
14. FATHER'S NAME Walter	First Lee	Middle Dukes.	Last	15. MOTHER'S MAIDEN NAME Charlotte	Middle Loretta	16. Last Deems	Address
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 197-11-0233	17. INFORMANT Hospital Records			Chestertown, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMATOSIS</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 MONTHS			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 174X				DUE TO, OR AS A CONSEQUENCE OF (b) <u>CA OF BREAST</u> DUE TO, OR AS A CONSEQUENCE OF (c)			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 170X							
19a. DATE OF OPERATION 2	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State		
22a. I certify that <input type="checkbox"/> (this hospital) attended the deceased from <u>9-8</u> , 19 <u>68</u> , to <u>9-9</u> , 19 <u>68</u> , that <input type="checkbox"/> (we) last saw the deceased alive on <u>9-8</u> - 19 <u>68</u> and that in <u>my</u> (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>DR. Oteiza MD</u>	22c. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. DATE SIGNED <u>9-9-68</u>					
22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS Chestertown, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE Sept. 11	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS SUDLERSVILLE	23d. LOCATION (City or Town) (County) (State) SUDLERSVILLE MD.				
24. FUNERAL DIRECTOR Edgar L. Lane - Church Hill, Md.	25a. REC'D BY REGISTRAR DATE SEP 16 1968			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

13001

2011-08-18

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13033

13045

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)				First	Middle	Last	2a. DATE OF DEATH	Month	Day	Year	2b. HOUR
Edward				E.	Clothier		Sept. 25,	1968	5:30 P.M.		
3. SEX		4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)			
Male		W			Sept. 7, 1887			81 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. COUNTY OF DEATH			
Maryland		U.S.A.			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Kent County			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.)			
Rock Hall				X X				Retired Waterman			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		12b. KIND OF BUSINESS OR INDUSTRY	
Maryland		Kent		Rock Hall		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		X X		X X	
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last		
Edward			Clothier		Emma				Deputy		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT		Address					
Yes, no, or unknown)		218-208422		Mrs. Edward Clothier, Rock Hall, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Coronary Thrombosis											
4100 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave Hyperlension											
rise to immediate cause (a), stating the underlying cause (b) last.											
DUE TO, OR AS A CONSEQUENCE OF											
Cordiol vascular (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
4201						YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept. 1</u> , 1968, to <u>Sept. 25</u> , 1968, that (I) (we) last saw the deceased alive on <u>Sept. 1</u> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		22c. DEGREE		ATTENDING PHYS.		<input checked="" type="checkbox"/> MED. DIRECTOR		<input type="checkbox"/> STAFF PHYS.		22d. DATE SIGNED	
Norbert C. Huber										Sept. 28/68	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS									
NORBERT C. HUBER		Rock Hall Md.									
23a. BURIAL/CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION (City or Town)		(County)		(State)	
BURIAL		9/28/68		Wesley Chapel		Rock Hall		Kent		Md.	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Edgar L. Sane		Churchill, Md.		OCT 3 1968		Charles Judge					

13034

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

13046

10. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED-NAME (Type or print)		First Anna	Middle Mae	Last Coleman	2a. DATE OF DEATH Month September	Day 7, 1968	Year 1968	2b. HOUR 9:15AM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH February 6, 1903		6. AGE (In years last birthday) 65		IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS. DAYS 0	IF UNDER 24 HRS. HOURS 0	IF UNDER 24 HRS. MIN. 0
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Kent Co.,		Md.			
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Kent & Queen Anne's Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Seamstress		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Kent		13c. CITY OR TOWN Rock Hall		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER X None			
14. FATHER'S NAME First Ulysses		Middle Grant	Last Col eman	15. MOTHER'S MAIDEN NAME First Annie		Middle Jane	Last Grulkey	Address Chestertown, Maryland			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. 216-10-2021		17. INFORMANT Hospital Records							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 174X		DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of Breast		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs							
Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last.		(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 170X											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from May 29, 1968 , to Sept. 7, 1968 , that (I) (we) last saw the deceased alive on Sept. 7, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE A. T. Keefe, M.D.		DEGREE M.D.		ATTENDING PHYS.		MED. DIRECTOR <input checked="" type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 9. 7. 68.	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS Chestertown, Maryland									
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE SEPT. 9		23c. NAME OF CEMETERY OR CREMATORIAL Wesley CHAPEL		23d. LOCATION (City or Town) Rock HALL		(County) Kent MD		(State)	
24. FUNERAL DIRECTOR Edgar L. Keefe		ADDRESS Church Hill Rd.		25a. REC'D BY REGISTRAR DATE SEP 16 1968		25b. REGISTRAR'S SIGNATURE Charles Judge					

6400

FOR STATE
HEALTH DEPT.

10 DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Page 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the death certificate. Page 3 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

13035

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13047

1. DECEASED-NAME (Type or Print)	First JOHN	Middle MATHEW	Last FENNEN	2a. DATE KNOWN <input checked="" type="checkbox"/> Month OF ESTI- MATED 9-5	Day 68	Year 1968	2b. HOUR 2:30 P.M.
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH 7-23-21	6. AGE In years In birthday 47 YRS.	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS DAYS 0	HOURS 0	MIN. 0
7a. BIRTHPLACE (State or foreign country) Phila. Pa.	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	9. COUNTY OF DEATH KENT	12c. DATE PRONONCED DEAD Month 9	Day 5	Year 1968	2d. HOUR 4:30 P.M.
10. CITY OR TOWN OF DEATH NEAR GALENA	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) BOAT YARD-GREENECK COopersmith			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Boat Yard-Greenneck Coopersmith	12b. KIND OF BUSINESS OR INDUSTRY NAVY YARD		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE No. J.	13b. COUNTY Camden	13c. CITY OR TOWN LINDENWALD	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input checked="" type="checkbox"/> NO	13e. STREET AND NUMBER 223 W. LINDEN AVE			
14. FATHER'S NAME First William	Middle Fennen	Last	15. MOTHER'S MAIDEN NAME First Marie	Middle	Last Scheifler		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes.	16b. SOCIAL SECURITY NO. (If you give war orders of service) W.W. 11	16c. INFORMANT 209-09-7215	ADDRESS GUSTAVE CORNEY-MTEPHRAIN, N.J.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201							
19a. DATE OF OPERATION 19-1		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 19			20. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.) 19				
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) 19	21f. LOCATION Street or R.F.D. No. 19	City or Town 19	County 19	State 19	
22a. I certify that I took charge of the remains described above, held on 19 Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE J. O. S. GULBRANDSEN		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 9-5-68	
EXAMINER'S NAME (Type) J. O. S. GULBRANDSEN, MD		ACT DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county) KENT			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Sept. 10, 1968	23c. NAME OF CEMETERY OR CREMATORIAL Gate of Heaven Cemetery	23d. LOCATION (City or Town) Berlin,	(County) Camden, N.J.	(State)		
24. FUNERAL DIRECTOR Edward Fellow Wellington	ADDRESS 19	25a. REC'D BY REGISTRAR DATE SEP 9 1968	25b. REGISTRAR'S SIGNATURE Charles Judge				

ANSWER

1000

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death or within 72 hours after death in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

13036

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13048

1. DECEASED-NAME (Type or Print)				First	Middle	Last	2a. DATE KNOWN OF ESTI- DEATH MATED				Month	Day	Year	2b. HOUR	
				Mary	Virginia	Finley	<input checked="" type="checkbox"/>				9	15	1968	4:40	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (in years last birthday)		IF UNDER 1 YEAR	IF UNDER 24 HRS			2c. DATE PRONOUNCED DEAD				2d. HOUR	
Female	White	2-17-1886		82 YRS.		MONTHS	DAYS	HOURS	MIN.	Month	Day	Year	4:55 M		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH									
Maryland		USA		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Kent									
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY			
Chestertown				Kent & Queen Anne's Hospital				Housewife							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?				13e. STREET AND NUMBER			
Maryland				Kent & Queen Church Hill				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				none			
14. FATHER'S NAME				First	Middle	Names	Co.	Lost	15. MOTHER'S MAIDEN NAME				First	Middle	Lost
William				Addison Bradley				Susan				Jane Massey			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO. (If yes give war or dates of service)				17. INFORMANT				ADDRESS			
no				216-14-2559				Hospital Records - Emergency Room Report				Chestertown, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4221 PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															Several years
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?							
								<input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.				City or Town		County		State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE		Robert W. Farr		CHIEF MEDICAL EXAMINER <input type="checkbox"/>											
EXAMINER'S NAME (Type)		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>													
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>													
		ADDRESS (Street, city, town, or county)													
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL				23d. LOCATION (City or Town) (County) (State)							
Burial		Sept. 17		Church Hill				Church Hill, Maryland							
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE							
Edgar L. Lane		Church Hill, Maryland		SEP 19 1968				Charles Judge							

13081

32

10-32-388

13037

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

13049

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 and 7, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First Arthur	Middle Vernon	Last Fowler	2a. DATE OF DEATH Month Sept.	Year 1968	2b. HOUR 7:29			
3. SEX Male	4. RACE White	5. DATE OF BIRTH June 27, 1908		6. AGE (In years last birthday) 60		IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS. DAYS 0	IF UNDER 24 HRS. HOURS 0	IF UNDER 24 HRS. MIN. 0
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Kent						
10. CITY OR TOWN OF DEATH Worton RFD	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) **-			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Engineering Tech.		12b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13b. COUNTY Kent	13c. CITY OR TOWN Worton	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER ---					
14. FATHER'S NAME First Adam	Middle C.	Last Fowler	15. MOTHER'S MAIDEN NAME First Hester	Middle Olivia	Last Carroll				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. 219-01-4199	17. INFORMANT Elisabeth H. Fowler	Address Worton, Md. RFD						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Myocardial Infarction APPROXIMATE INTERVAL 4109 BETWEEN ONSET AND DEATH FEW MINUTES									
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u> last. (b) Coronary Artery Disease SEVERAL YEARS									
DUE TO, OR AS A CONSEQUENCE OF (c) A.S.C.V.D. SEVERAL YEARS									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
4201 OBESITY, CA OF PROSTATE.									
19a. DATE OF OPERATION 4201	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. 19 P.M.	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Month Day Year 19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that <input type="checkbox"/> (this hospital) attended the deceased from 6-23 , 19 68 , to 9-8- , 19 68 , that <input type="checkbox"/> (we) last saw the deceased alive on 19 , and that in <input type="checkbox"/> (my) <input type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input type="checkbox"/> (we) <input type="checkbox"/> (did) <input type="checkbox"/> (did not) view the body after death.									
22b. SIGNATURE Jorge A. Oteiza DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> DATE SIGNED 9-9-68									
22d. PHYSICIAN'S NAME (Type) JORGE A. OTEIZA MD 22e. ADDRESS CHESTERTOWN - MARYLAND.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 9-11-68	23c. NAME OF CEMETERY OR CREMATORIAL Galena Cemetery	23d. LOCATION (City or Town) (County) (State) Galena Kent Md.						
24. FUNERAL DIRECTOR Victor N. Kennedy	ADDRESS Still Pond, Md.	25a. REC'D BY REGISTRAR DATE SEP 1 1968		25b. REGISTRAR'S SIGNATURE Charles Judge					

REPORT

TO THE CHIEF OF STAFF

10 SEPTEMBER

1968

FOR STATE
HEALTH DEPT.

Any delay is
necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to
the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page
5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of
Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

13038

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13050

1. DECEASED-NAME (Type or Print)	First	Middle	Lost	2a. DATE KNOWN BY ESTI- MATED	Month	Day	Year	2b. HOUR				
<i>Elva</i>				<i>Gardiner</i>				<input type="checkbox"/>	Sept	22	1968	6:00 P.M.
3. SEX	4. RACE	S. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. DAYS	HOURS		MIN.	2c. DATE PRONOUNCED DEAD	2d. HOUR		
<input type="checkbox"/> F	<input type="checkbox"/> W	<i>Jan 3, 1897</i>	77 YRS.						Month <i>Sept</i> Day <i>22</i> Year <i>1968</i>	6:00 P.M.		
7. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8.	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH				Md.				
<i>Del.</i>	<i>U.S.A.</i>			<i>Kent County</i>								
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY						
<i>Kennedyville, Md.</i>	<i>Rural</i>	<i>Housewife</i>				<i>home</i>						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER								
<i>Md.</i>	<i>Kent</i>	<i>Millington</i>	<input type="checkbox"/> YES <input type="checkbox"/> NO									
14. FATHER'S NAME	First	Middle	Lost	15. MOTHER'S MAIDEN NAME	First	Middle	Lost					
<i>William</i>				<i>Ellen - wife</i>				<i>Hettie</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16b. SOCIAL SECURITY NO.	17. INFORMANT					ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
<input type="checkbox"/> No.		<i>Mrs. Wm Schelte</i>					<i>Kennedyville, Md.</i>			<i>2 years</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)).												
PART I. DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) <i>Cardiovascular Disease</i>												
DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. (b) <i>4129</i>												
DUE TO, OR AS A CONSEQUENCE OF												
(c) <i>4221</i>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?		
										<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)								
				<i>19</i>								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State		
22a. I certify that I took charge of the remains described above, held on <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
22b. DATE SIGNED <i>9/22/68</i>												
ACTUAL SIGNATURE <i>Robert W. Farr</i>												
EXAMINER'S NAME (Type) <i>ROBERT W. FARR</i>												
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM				23d. LOCATION (City or Town)		(County) (State)		
<i>Burial</i>		<i>9/25/68</i>		<i>Millington Cemetery</i>				<i>Millington, Kent, Md.</i>				
24. FUNERAL DIRECTOR		ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
<i>Edward Fellows & Son,</i>		<i>Millington, Md. 21651</i>						<i>Charles Judge</i>				
DATE		SEP 25 1968										

3
1
13039

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13051

10. **HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

11. **FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 2 hours after death.

1. DECEASED-NAME (Type or print)				First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR 3:30 P.M.			
3. SEX				4. RACE		5. DATE OF BIRTH 3/5/62			6. AGE (In years last birthday) 66 YRS.				
7a. BIRTHPLACE (State or foreign country)				7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore				
10. CITY OR TOWN OF DEATH Rock Hall				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Farming			12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md				13b. COUNTY Baltimore		13c. CITY OR TOWN Rock Hall			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
14. FATHER'S NAME Wm W. Goodman				15. MOTHER'S MAIDEN NAME Mary Anne Pearce		16. SOCIAL SECURITY NO. 211-30-9949			17. INFORMANT Mrs. Mary Freeman				
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No				18b. ADDRESS		18c. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1621				19. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		20. DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			21. DUE TO, OR AS A CONSEQUENCE OF Bronchogenic carcinoma				
22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 1621				23. MEDICAL CERTIFICATION		24. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.			21g. CITY OR TOWN			21h. COUNTY					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE Kendell L. Burkett, Jr.			22c. DEGREE ATTENDING PHYS., <input type="checkbox"/> MED. DIRECTOR, <input type="checkbox"/> STAFF PHYS., <input type="checkbox"/>			22d. DATE SIGNED Sept 2, 1968					
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS 10 Cross St. Elizabeton, Md.			23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE Sept 3, 1968			23c. NAME OF CEMETERY OR CREMATORIAL Wesley Chapel		
24. FUNERAL DIRECTOR Garrison O. Williams, Chestertown, Md.		24d. ADDRESS Chestertown, Md.			25a. REC'D BY REGISTRAR SEP 6 1968			25b. REGISTRAR'S SIGNATURE Charles Judge					

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13040

13052

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First Mary	Middle E.	Lost Gould	2a. DATE OF DEATH Month September	2b. HOUR Doy 2, 1968	
3. SEX Female	4. RACE Colored	5. DATE OF BIRTH December, 25, 1883		6. AGE (in years last birthday) 84	IF UNDER 1 YEAR MONTHS YRS.	IF UNDER 24 HRS. DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Del.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH Kent			
10. CITY OR TOWN OF DEATH Millington	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) None		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife	12b. KIND OF BUSINESS OR INDUSTRY Home		
13a. USUAL RESIDENCE (Where deceased admission) STATE Md.	lived, if institution: Residence before Kent	13c. CITY OR TOWN Millington	13d. INSIDE CITY LIMITS? YES	13e. STREET AND NUMBER ---		
14. FATHER'S NAME First Unknown	Middle 	Lost 	15. MOTHER'S MAIDEN NAME First Millie	Middle 	Lost Watson	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No.	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 222-16-0498B	17. INFORMANT Willis Gould. Husband. Millington, Md. 21651	Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 days.		
431.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.				DUE TO, OR AS A CONSEQUENCE OF Hypertension		
(b) Diabetes				DUE TO, OR AS A CONSEQUENCE OF Diabetes		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 331X						
19a. MEDICAL CERTIFICATION	19b. DATE OF OPERATION	19c. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Doy Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from Aug. 18, 1968 , to Sept 2, 1968 , that (I) (we) last saw the deceased alive on Aug 31 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Geza Koralewski	DEGREE 	ATTENDING PHYS. 	MED. DIRECTOR 	STAFF PHYS. 	22c. DATE SIGNED 9.4.68	
22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS Millington, Md. 21651					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 9/7/68	23c. NAME OF CEMETERY OR CREMATORIAL Millington Cemetery	23d. LOCATION (City or Town) Millington	(County) Kent	(State) Md.	
24. FUNERAL DIRECTOR Edward Fellows & Son,	ADDRESS Millington, Md. 21651	25a. REC'D BY REGISTRAR DATE SEP 6 1968	25b. REGISTRAR'S SIGNATURE Charles Judge			

Score

100% - 100% correct, 100% of the time, 100% of the time

100%

80%

100% correct

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80% correct

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100% correct

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13053

13041

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.
 To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First Sarah	Middle C	Last Haver	2a. DATE OF DEATH 9/5/1968	Day	Year	2b. HOUR 8:50P M
3. SEX F emale	4. RACE White	S. DATE OF BIRTH 2-1-97			6. AGE (In years last birthday) 11	IF UNDER 1 YEAR MONTHS YRS.	IF UNDER 24 HRS. DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Penns.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Kent County	
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Kent & Queen Anne's			12a. USUAL OCCUPATION (Kind of work done during past of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY 6666C
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13b. COUNTY Kent	13c. CITY OR TOWN Chestertown	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER -----			
14. FATHER'S NAME Albert	First Middle Borcky	Last Borcky	15. MOTHER'S MAIDEN NAME Rosa	Middle Reppert	Lost		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 194-22-8552	17. INFORMANT Hosp. records			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOGENIC SHOCK</u> 4100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>MYOCARDIAL INFARCTION</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>H.C.V.D</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 HOURS FEW days							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201 OBESITY.							
19a. DATE OF OPERATION X	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <input type="checkbox"/> YES <input type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING □ OR CONTRIBUTING □ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While at work Not while at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State		
22a. I certify that (I) (this hospital) attended the deceased from 9-5-1968, to 9-5-1968, that (I) (we) last saw the deceased alive on 9-5-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Dr. Oteiza</u>	DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 9-5-68.			
22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS Chestertown, Maryland						
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 9/9/68	23c. NAME OF CEMETERY OR CREMATORIUM IMMACULATE HEART CEMETERY	23d. LOCATION (City or Town) LINWOOD, DEL. CO., PENNA.	(County)	(State)		
24. FUNERAL DIRECTOR <u>J. Willis Wells</u>	ADDRESS Chestertown, Md.	25a. REC'D BY REGISTRAR DATE SEP 9 1968	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
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13042

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13054

1. DECEASED-NAME (Type or print)	First Samuel	Middle David	Last Hurlock	2a. DATE OF DEATH 9 Month 5 Day 168 Year	2b. HOUR 5:50P M	
3. SEX M	4. RACE W	5. DATE OF BIRTH 6/8/68		6. AGE (In years lost birthday) 64	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	WIDOWED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Kent County
10. CITY OR TOWN OF DEATH Chestertown	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Kent-Queen Anne's			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Railway Postal Service		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13b. COUNTY Q.A. Co.	13c. CITY OR TOWN Crumpton	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES	13e. STREET AND NUMBER -----	12b. KIND OF BUSINESS OR INDUSTRY Post Off.	
14. FATHER'S NAME Samuel	First S.	Middle Hurlock	15. MOTHER'S MAIDEN NAME Maude	Middle Hurlock	Last Hurlock	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (Unknown) No	16b. SOCIAL SECURITY NO. _____	17. INFORMANT Hosp. records	Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GANGRENE LEFT HEEL</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 2509 <u>DIABETES MELLITUS</u> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 260X A.S.C.V.D.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS SEVERAL YEARS.
19a. DATE OF OPERATION 260X		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that <input type="checkbox"/> (this hospital) attended the deceased from <u>8-14-</u> , 19 <u>68</u> , to <u>9-5</u> , 19 <u>68</u> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <u>9-5-</u> 19 <u>68</u> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>J.R. Oteiza</u>		DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 9-5-68	
22d. PHYSICIAN'S NAME (Type) <u>J.R. Oteiza, M.D.</u>		22e. ADDRESS Chestertown, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 9/8/68	23c. NAME OF CEMETERY OR CREMATORIAL Crumpton Cemetery	23d. LOCATION (City or Town) Crumpton	(County) Q.A.	(State) Md.
24. FUNERAL DIRECTOR Edward Fellows & Son,		ADDRESS Millington, Md.	25a. REC'D BY REGISTRAR DATE SEP 10 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13043

13055

10. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

10. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First George	Middle Beacher	Last Jones Sr.	2a. DATE OF DEATH 9-8-68 Month	2b. HOUR 5:45P
3. SEX M	4. RACE W	5. DATE OF BIRTH 2-27-190		6. AGE (In years last birthday) 78	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Penns.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Kent County		
10. CITY OR TOWN OF DEATH Chestertown	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) K-QA Hospital	12a. USUAL OCCUPATION (Kind of work done during most working life, even if retired.) Retired		12b. KIND OF BUSINESS OR INDUSTRY Storekeeper	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13b. COUNTY Kent Co	13c. CITY OR TOWN Millington	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER -----	
14. FATHER'S NAME William	First Middle Jones	15. MOTHER'S MAIDEN NAME Dena	Middle Last Carrow		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. 215-26-5105 A	17. INFORMANT Hosp. Records	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) C.V.A 4120 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) H.C.V.D DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF UNKNOWN					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o) 443X OBESITY					
19a. DATE OF OPERATION 2/	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (1) (this hospital) attended the deceased from 9-8-68, to 9-8-68, that (1) (we) last saw the deceased alive on 9-8-68 and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Dr. Oteiza MD	22c. DATE SIGNED 9-9-68				
22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS CHESTER TOWN - MARYLAND				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Sept. 11, 1968	23c. NAME OF CEMETERY OR CREMATORIUM Millington Cemetery	23d. LOCATION (City or Town) Millington	(County) Kent	(State) Md.
24. FUNERAL DIRECTOR Edward Fellows & Son,	ADDRESS Millington, Md. 21651	25a. REC'D BY REGISTRAR DATE SEP 13 1968	25b. REGISTRAR'S SIGNATURE Charles Judge		

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Page 22 of 22

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13056

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First Emma	Middle Clara	Last Lamb	2a. DATE OF DEATH Sept. 30, 1968	Month Sept.	Day 30	Year 1968	2b. HOUR 12 Noon
3. SEX Female		4. RACE White		5. DATE OF BIRTH October 1, 1888		6. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Kent Co.,			
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Kent & Queen Anne's Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working-life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Kent		13c. CITY OR TOWN Chestertown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Rt. #1, Morgnec Road	
14. FATHER'S NAME First Edwin		Middle Boulter	Last	15. MOTHER'S MAIDEN NAME Mamie		Middle Last Kelley			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. 219-34-3743		17. INFORMANT Hospital Records, Chestertown, Maryland		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic hypertension cardio vascular</i> 5 years. DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u> last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>443X</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____					
22a. I certify that (I) (this hospital) attended the deceased from Sept. 20, 1968, to Sept. 30, 1968, that (I) (we) last saw the deceased alive on Sept. 30, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>A. C. Dick, M.D.</i>		22c. DEGREE M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. DATE SIGNED 9-30-68			
22d. PHYSICIAN'S NAME (Type) A. C. Dick, M.D.		22e. ADDRESS Chestertown, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10/3/68		23c. NAME OF CEMETERY OR CREMATORIAL Chester Cemetery		23d. LOCATION (City or Town) Chestertown		(County) Md.	
24. FUNERAL DIRECTOR <i>J. Willis Wells</i>		ADDRESS Chestertown, Md.		25a. REC'D BY REGISTRAR DATE OCT 3 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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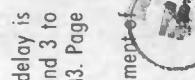
2000-01-02

FOR STATE
HEALTH DEPT.

13045

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

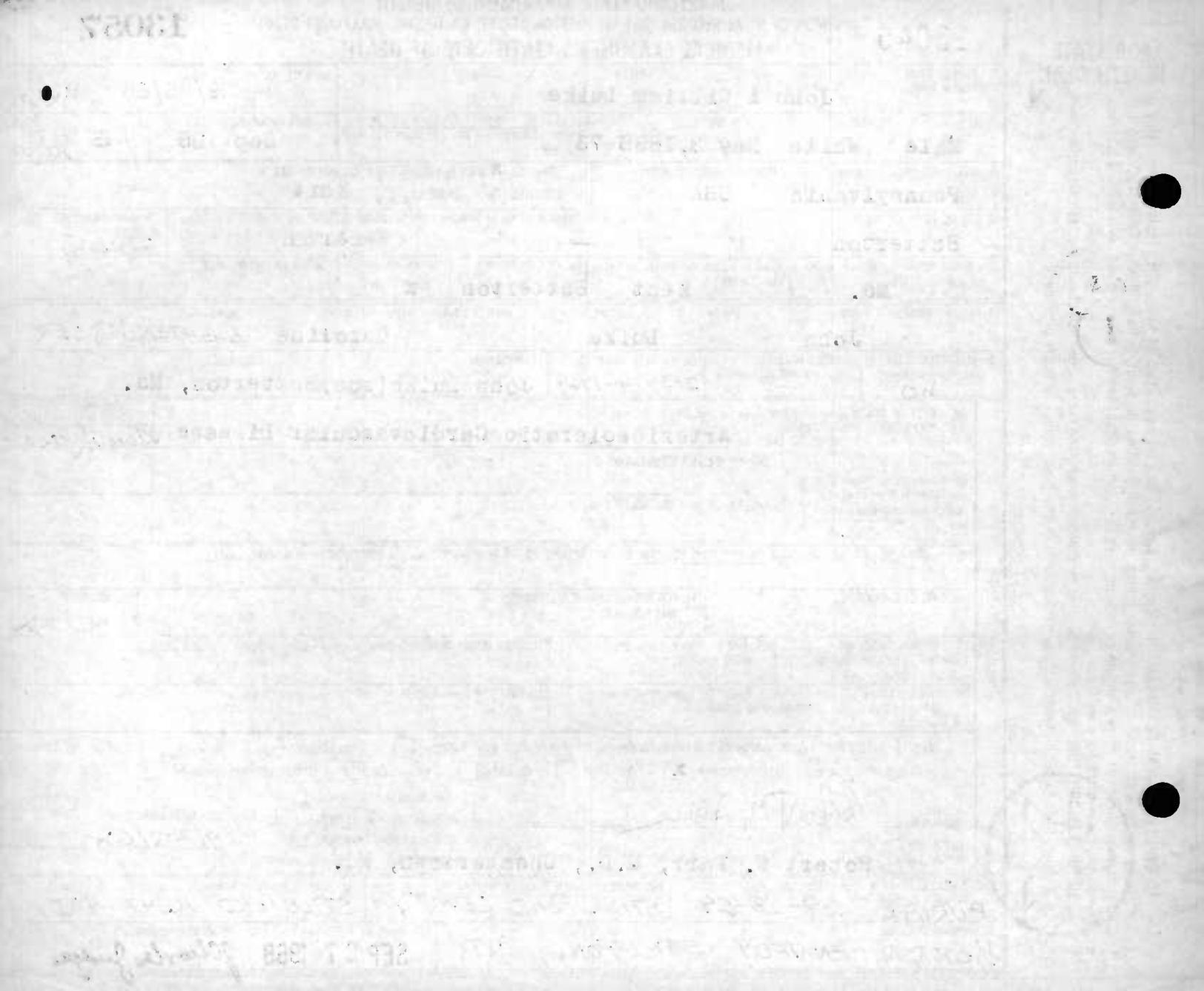
13057



Any delay is
necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to
the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page
5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of
Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print)		First	Middle	Last	2a. DATE KNOWN OF DEATH ESTI: DEATH MATED	Month 9/25/68 19	Day 9 19	Year 9 19	2b. HOUR 9:30 AM
John & William Luike									
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years by birthday)	IF UNDER 1 YEAR MONTHS YRS.	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD Month Sep Year 1968 10:30 AM		2d. HOUR	
Male	White	May 2, 1895	73						
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED		9. COUNTY OF DEATH			
Pennsylvania		USA				Kent			
10. CITY OR TOWN OF DEATH Betterton		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during period of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
				Waterman		Fishing			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER			
Md.		Kent		Betterton					
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle	Last	
John				Luike	Caroline			LIGHTENBERGER	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT		ADDRESS			
no		213-14-1969		John Luike (son) Betterton, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4129 <i>several years</i>									
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4221									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town	County	State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Robert W. Farr</i>									
M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>									
22b. DATE SIGNED 9/25/68									
EXAMINER'S NAME (Type) Robert W. Farr, M.D., Chestertown, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 9-28-68		23c. NAME OF CEMETERY OR CREMATORIAL STILL POND CEMTY.		23d. LOCATION (City or Town) STILL POND KENT MD		(County) KENT (State) MD	
BURIAL									
24. FUNERAL DIRECTOR		ADDRESS VICTOR N. KENNEDY STILL POND, MD.		25a. REC'D BY REGISTRAR DATE SEP 27 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13046

13058

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then place remove carbon papers pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED-NAME (Type or print)	First Anna	Middle Cecelia	Last Massey	2a. DATE OF DEATH Month September	2b. HOUR Year 1968		
3. SEX Female	4. RACE White	5. DATE OF BIRTH June 29, 1901		6. AGE (In years last birthday) 67	IF UNDER 1 YEAR MONTHS YRS.	IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? US	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH Kent Co.,	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			
10. CITY OR TOWN OF DEATH Chestertown	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Kent & Queen Anne's Hospital			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Queen Anne	13c. CITY OR TOWN Church Hill	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	13e. STREET AND NUMBER None			
14. FATHER'S NAME First Thomas	Middle Anthony	Last Mench	15. MOTHER'S MAIDEN NAME First Margaret	Middle Catherine	Last Uhlman		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 218-10-4549	17. INFORMANT Hospital Records	Address Chestertown, Maryland		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 mos.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma 151.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) of Stomach DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 151X							
19a. DATE OF OPERATION 9-9-68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Gastric Carcinoma		20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. 19 P.M.	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Month 19				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from August 29, 1968 , to Sept. 17, 1968 , that (I) (we) last saw the deceased alive on September 17, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE 		DEGREE ATTENDING PHYS.	MED. DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 9-17-68		
22d. PHYSICIAN'S NAME (Type) A. T. Keefe, M. D.		22e. ADDRESS Chestertown, Maryland 21620					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Sept. 20	23c. NAME OF CEMETERY OR CREMATORIAL Church Hill	23d. LOCATION (City or Town) Church Hill	(County) Q.A. Md.	(State)	
24. FUNERAL DIRECTOR 		ADDRESS Church Hill, Md.	25a. REC'D BY REGISTRAR DATE SEP 23 1968	25b. REGISTRAR'S SIGNATURE 			

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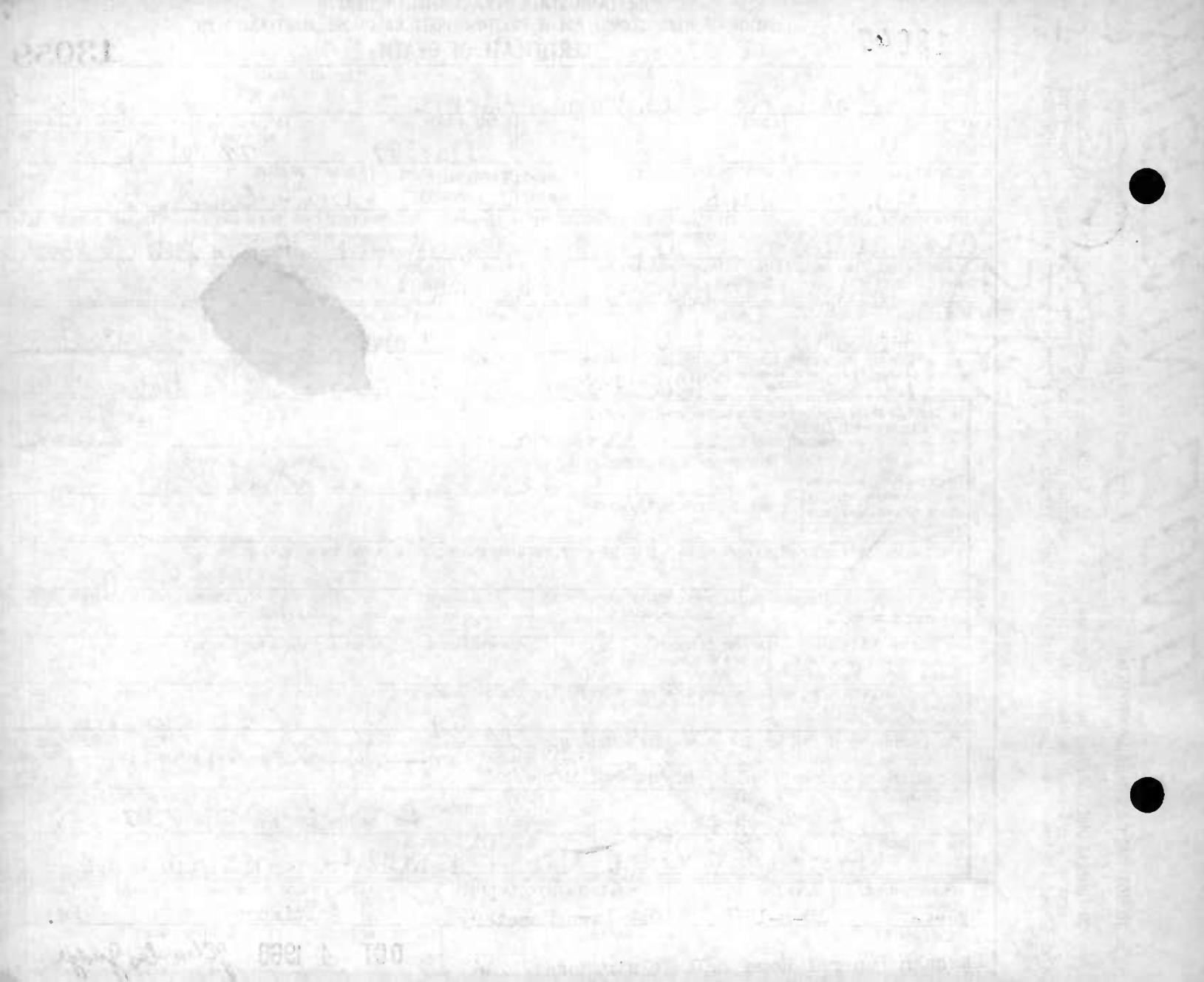
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13059

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. **TO** **Health** **Dept.** **should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.**

13047				2b. HOUR 4:10 P.M.				
1. DECEASED-NAME (Type or print)		First <i>Frederick William</i>	Middle <i>Norris</i>	2a. DATE OF DEATH Month 9		Day 30	Year 1968	
3. SEX <i>M</i>		4. RACE <i>W</i>	5. DATE OF BIRTH <i>3-6-91</i>		6. AGE (In years last birthday) <i>77</i> YRS.			
7a. BIRTHPLACE (State or foreign country) <i>Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Kent County</i>			
10. CITY OR TOWN OF DEATH <i>Chestertown</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Kent Queen Anne Hospital</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Retired Farmer</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Farming</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Queen Anne Church Hill</i>	13c. CITY OR TOWN <i>Chestertown</i>		13d. INSIDE CITY LIMITS? <i>YES</i> <input type="checkbox"/> <i>NO</i> <input type="checkbox"/>	13e. STREET AND NUMBER <i>- - -</i>		
14. FATHER'S NAME First <i>Henry</i>		Middle <i>Norris</i>	Last	15. MOTHER'S MAIDEN NAME First <i>Emma</i>		Middle	Last <i>Brehm</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>NO</i>		16b. SOCIAL SECURITY NO. <i>216-12-3767</i>		17. INFORMANT <i>Hospital Records</i>		Address <i>Chestertown, Md.</i>		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Armenia</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>188X</i> (b) <i>Carcinoma of Bladde</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>2 yrs</i>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>1810</i>								
19a. DATE OF OPERATION <i>—</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>—</i>		20a. AUTOPSY? <i>YES</i> <input type="checkbox"/> <i>NO</i> <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>—</i>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.) <i>—</i>		21d. LOCATION Street or R.F.D. No. City or Town County State			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) <i>—</i>	21f. LOCATION Street or R.F.D. No. City or Town County State		22a. I certify that (I) (this hospital) attended the deceased from <i>9-23, 1968</i> , to <i>7-20, 1968</i> , that (I) (we) last saw the deceased alive on <i>9-30, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <i>C. Keefe</i>		DEGREE <i>MD.</i>	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>9-30-68</i>				
22d. PHYSICIAN'S NAME (Type) <i>Arthur T. Keefe, MD</i>		22e. ADDRESS <i>Chestertown Maryland</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>10-4-1968</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Oak Lawn Cemetery</i>	23d. LOCATION (City or Town) <i>Baltimore</i>		(County) <i>—</i>	(State) <i>Md.</i>	
24. FUNERAL DIRECTOR <i>Lassahn Funeral Home 7401 Belair Road 21236</i>		ADDRESS		25a. REC'D BY REGISTRAR <i>OCT 4 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13048

13060

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH	Month	Day	Year	2b. HOUR	
Dr. GUSTAV Adolph PapperMAN						Sept. 15 1968			12 45 AM		
3. SEX		4. RACE		5. DATE OF BIRTH		Age 85 yrs		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR	
MALE		WHITE		10-22-1882		865 YRS.		MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. COUNTY OF DEATH		Md	
MARYLAND		UNITED STATES		<input checked="" type="checkbox"/>		<input type="checkbox"/>		KENT CO.			
8. MARRIED		<input checked="" type="checkbox"/>		WIDOWED		<input type="checkbox"/>		DIVORCED			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY					
ChesterTOWN		KENT and Queen Anne's Co.		MINISTER							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER			
MARYLAND		KENT Co.		Rock Hall		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last		
Ernest					EMMA						
XXXXXX		Adolph PapperMAN				Pfeiffer					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address					
		1918		217 36 1706		Hospital Records		ChesterTOWN, Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 das											
DUE TO, OR AS A CONSEQUENCE OF											
(b) <u>A. S. C. O. D.</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
4201											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <u>9-14</u> , 1968, to <u>9-15</u> , 1968, that (I) (we) last saw the deceased alive on <u>9-15</u> 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		<u>Harry P Ross MD</u>		DEGREE		ATTENDING PHYS.		<input checked="" type="checkbox"/> MED. DIRECTOR		<input type="checkbox"/> STAFF PHYS.	
22d. PHYSICIAN'S NAME (Type)		HARRY P Ross		22e. ADDRESS		ChesterTOWN, Md 21620				22c. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION (City or Town)		(County)		(State)	
Burial		9/18/68		Riverview Cemetery		Wilmington, Delaware					
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Florrie Wells		Chestertown, Md.		DATE SEP 18 1968		Charles J. Jones					

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13061

1		13049	First ROLAND	Middle GEORGE	Last PORTER	2a. DATE OF DEATH Month 9 Day 8 Year 1968	2b. HOUR 12 20 PM
2		3. SEX Male	4. RACE White	S. DATE OF BIRTH 7-9-1887	6. AGE (In years last birthday) 81	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. DAYS HOURS MIN.
3		7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? US	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Kent		
4		10. CITY OR TOWN OF DEATH Chestertown	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Kent & Queen Anne's	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Truck Driver	12b. KIND OF BUSINESS OR INDUSTRY Md.		
5		13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Kent	13c. CITY OR TOWN Chestertown	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 230 Cross St.	
6		14. FATHER'S NAME Henry ? Porter	15. MOTHER'S MAIDEN NAME Sarah	16. SOCIAL SECURITY NO. 214 01 5753	17. INFORMANT Hospital Records	Address Chestertown, Md.	
7		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 185X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	DUE TO, OR AS A CONSEQUENCE OF (b) CA OF PROSTATE DUE TO, OR AS A CONSEQUENCE OF (c)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH FEW WEEKS 2 YEARS	
8		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(o) 1778					
9		19a. DATE OF OPERATION 1978	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
10		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
11		21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	
12		22a. I certify that (I) (this hospital) attended the deceased from 8-18, 1968, to 9-8, 1968, that (I) (we) last saw the deceased alive on 9-7-1968 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
13		22b. SIGNATURE Dr. Oteiza	DEGREE ATTENDING PHYS.	22c. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 9-8-68		
14		22d. PHYSICIAN'S NAME (Type) JORGE A. OTEIZA M.D.	22e. ADDRESS CHESTERTOWN - MARYLAND				
15		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 9/10/68	23c. NAME OF CEMETERY OR CREMATORIAL Chester Cemetery	23d. LOCATION (City or Town) Chestertown, Md.	(County) Md.	
16		24. FUNERAL DIRECTOR Willis Wells	ADDRESS Chestertown, Md.	25a. REC'D BY REGISTRAR DATE SEP 11 1968	25b. REGISTRAR'S SIGNATURE Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13050

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13062

Item#1. FilmGh05 10/7/68 km

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
Elizabeth	Jones	D.	Ramsey	9	28	68	2.15 M
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Female	White	January 11-16-1896		72 YRS.			
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Delaware	U.S.A.			Queen Anne Kent		Kent	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Chestertown	Kent & Queen Anne's			Housewife		none	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
Md.	Queen Anne's	Chestertown					
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle
John	A	Danly		Mary			Loller
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)	16b. SOCIAL SECURITY NO.	17. INFORMANT		Address			
no	221-07-3185	Kent & Queen Anne's Hospital, Chestertown, Md					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMATOSIS</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 MONTHS</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CARCINOMA OF LARGE BOWEL</u> 3 YEARS							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>6-30</u> , 19 <u>68</u> , to <u>9-28</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>9-29</u> - 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Jorge Oteiza</u>		DEGREE	ATTENDING PHYS.	<input checked="" type="checkbox"/>	MED. DIRECTOR	<input type="checkbox"/>	STAFF PHYS.
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		22c. DATE SIGNED <u>9-30-68</u>			
Jorge Oteiza M.D.		Chestertown, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORIUM	23d. LOCATION (City or Town)		(County)	(State)
Burial		9/30/68	Crumpton Cemetery	Crumpton, Md.			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE		
Willis Wells, Chestertown, Md.				DATE OCT 3 1968			<u>Charles Judge</u>

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13051

13063

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First Clara	Middle Busey	Last Rasin	2a. DATE OF DEATH Month September	Day 2, 1968	2b. HOUR 5:05	
3. SEX Female	4. RACE White	5. DATE OF BIRTH July 11, 1893		6. AGE (in years last birthday) 75	IF UNDER 1 YEAR MONTHS YRS.	IF UNDER 24 HRS. MONTHS DAYS HOURS MIN Md.	
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? US	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED	9. COUNTY OF DEATH Kent Co.,	10. CITY OR TOWN OF DEATH Chestertown	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Kent & Queen Anne's Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife	12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Kent	13c. CITY OR TOWN Chestertown	13d. INSIDE CITY LIMITS? YES	13e. STREET AND NUMBER Rt. #1			
14. FATHER'S NAME Harrison	First Earl	Middle Cooper	15. MOTHER'S MAIDEN NAME Elizabeth	Middle Ivens	Lost		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? No	16b. SOCIAL SECURITY NO. 218-20-5306	17. INFORMANT Hospital Records	Address Chestertown, Maryland	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion							
5749 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterosclerosis C.V.D. Coron							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 5848.0. Cholecystosclerosis							
19a. DATE OF OPERATION 8/30/68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Gall-Stones		20a. AUTOPSY? YES	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from August 19, 1968 , to September 2, 1968 , that (I) (we) last saw the deceased alive on September 2, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE 		DEGREE MD.	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 9. 3. 68	
22d. PHYSICIAN'S NAME (Type) A. T. Keefe, M. D.		22e. ADDRESS Chestertown, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE SEPT. 4, 1968	23c. NAME OF CEMETERY OR CREMATORIAL CHESTER CEMETARY		23d. LOCATION (City or Town) CHESTERTOWN	(County) KENT	(State) Md.
24. FUNERAL DIRECTOR Marion V. Williams, Chestertown Md		ADDRESS Marion V. Williams, Chestertown Md	25a. REC'D BY REGISTRAR SEP 6 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

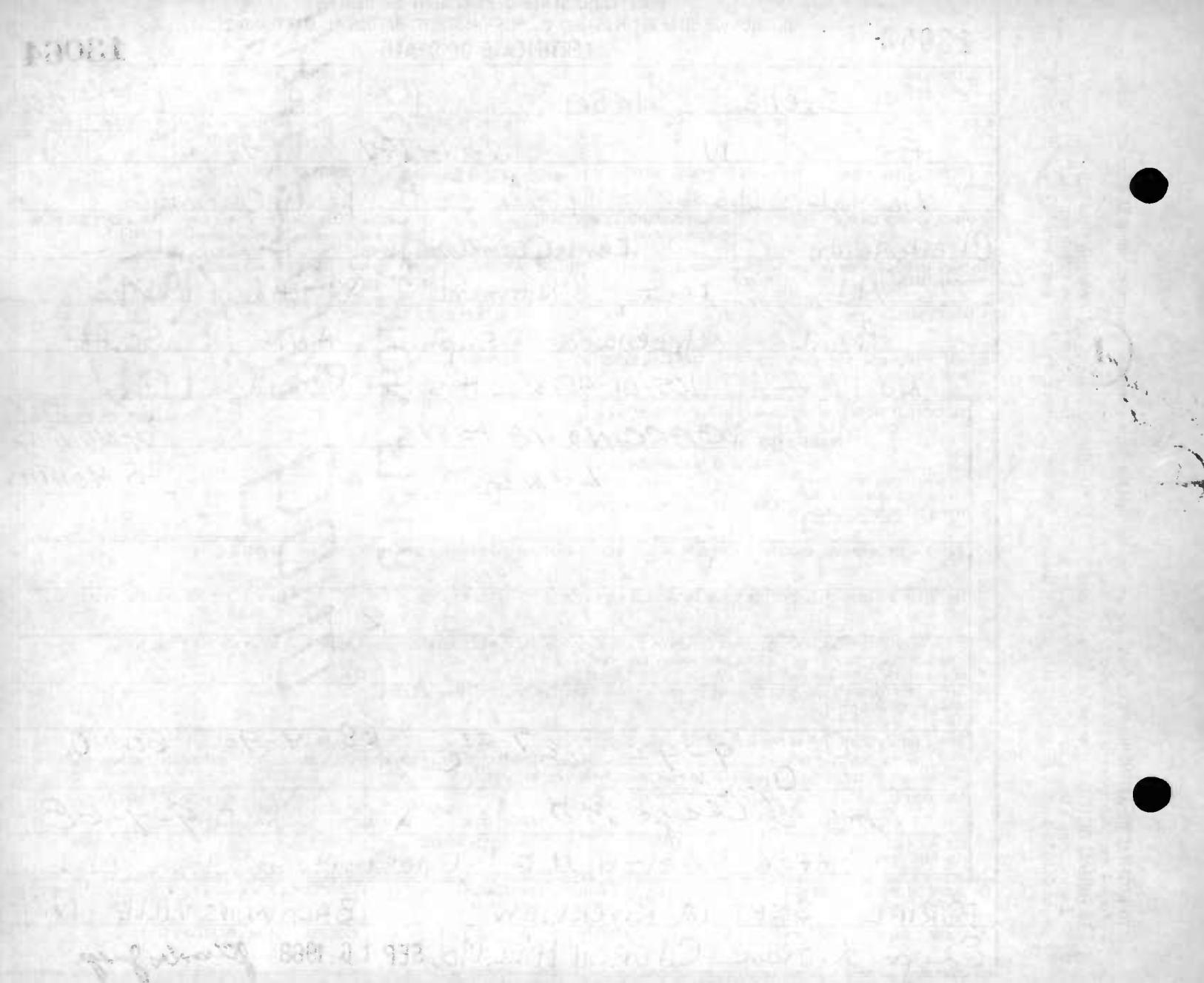
13052

13064

1. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

2. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper from pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED-NAME (Type or print)	First Irene	Middle Mabel	Lost Ward	2a. DATE OF DEATH Month 9	9 Day	68 Year	2b. HOUR P 7:30	
3. SEX F	4. RACE W	5. DATE OF BIRTH 2-14-1897		6. AGE (In years lost birthday) 71 YRS.	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. DAYS	IF UNDER 24 HRS. HOURS	
7a. BIRTHPLACE (State or foreign country) New York	7b. CITIZEN OF WHAT COUNTRY? U.S.A	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Kent County					
10. CITY OR TOWN OF DEATH Chestertown	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Kent Queen Anne Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13b. COUNTY Kent	13c. CITY OR TOWN Chestertown	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 10 Chestertown Estates				
14. FATHER'S NAME Pearl	First Middle Last	15. MOTHER'S MAIDEN NAME Greenwood	First Sophia	Middle ANN	Lost Scott			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. 105-01-4583		17. INFORMANT Hospital Records	Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA to SIS</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>C. A. LUNG</u> (b) <u>C. A. LUNG</u> DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>163 X</u>								
19a. DATE OF OPERATION MEDICAL CERTIFICATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State			
22a. I certify that (1) (this hospital) attended the deceased from 7-23-1968 to 9-9-1968 that (1) (we) last saw the deceased alive on 9-9-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>Dre. Oteiza MD</u>	DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 9-9-68				
22d. PHYSICIAN'S NAME (Type) Sorge Oteiza, M.D.	22e. ADDRESS Chestertown, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE SEPT. 12	23c. NAME OF CEMETERY OR CREMATORIAL RIVERVIEW	23d. LOCATION (City or Town) BALDWINSVILLE	(County) N.Y.	(State)			
24. FUNERAL DIRECTOR Edgar L. Lane - CHURCH HILL MD	ADDRESS Edgar L. Lane - CHURCH HILL MD	25a. REC'D BY REGISTRAR SEP 16 1968	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13065

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hrs after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please give carbon papers. Please and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First MARION	Middle	Lost WEEKS	2a. DATE OF DEATH Sept. 26, 1968	2b. HOUR M
3. SEX female	4. RACE white	S. DATE OF BIRTH July 18, 1890	6. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Washington D.C.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Kent Co. Md.		
10. CITY OR TOWN OF DEATH Chestertown	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 107 Water St.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Librarian & Housewife	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Kent	13c. CITY OR TOWN Chestertown	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 107 Water St.	
14. FATHER'S NAME First William F. Weeks	Middle	Last	15. MOTHER'S MAIDEN NAME Mary Alice Denton	Middle	Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) none known	17. INFORMANT Hospital Records	Address Chestertown, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c)			11 hrs. Years		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from 1-15, 19 68, to 9-26, 19 68, that (I) (we) last saw the deceased alive on 9-26-68 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>A. C. Dick</u> M.D.	DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 9/26/68	
22d. PHYSICIAN'S NAME (Type) A. C. Dick, M.D.	22e. ADDRESS Chestertown, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 9/28/68	23c. NAME OF CEMETERY OR CREMATORIUM St. Paul Cemetery near Chestertown, Md.	23d. LOCATION (City or Town) (County) (State)		
24. FUNERAL DIRECTOR <u>J. Willis Wells</u>	ADDRESS Chestertown, Md.	25a. REC'D BY REGISTRAR DATE SEP 30 1968	25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>		

